

- NEW RETIREE                       NEW LTD PARTICIPANT                       ADDRESS CHANGE  
 QUALIFIED LIFE EVENT                       TERMINATE INSURANCE

- RETIRED     DISABLED  
 SURVIVING SPOUSE

### Retirement System

- ASRS (ZA)     PSPRS, CORP, EORP (ZP)     OPTIONAL (ZT)

EFFECTIVE DATE:	DECEASED MEMBER'S NAME:	DECEASED DATE:
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### MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED	DATE OF BIRTH
		<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE	
STREET ADDRESS			COUNTY OF RESIDENCE	
CITY, STATE, ZIP CODE		E-MAIL ADDRESS (Mandatory)		
LAST DAY WORKED	DATE RETIRED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	HOME PHONE NUMBER (    )	AGENCY

Are you enrolling a same-sex Domestic Partner?    (circle one)                      Yes    or    No

To qualify a same-sex Domestic Partner for the first time, you will need to complete and submit the DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized). This form can be found on the Benefit Options website at [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov).

### DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH <i>(Required)</i>	RELATIONSHIP CODE S=Spouse D=Same-Sex Domestic Partner C=Child G=Guardian P=Placed for adoption T=Stepchild	MEDICARE A=Medicare A B=Medicare B C=Medicare A & B D=Medicare Unknown E=No Medicare	SOCIAL SECURITY NUMBER <i>(Required)</i>	MALE OR FEMALE M OR F	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
MEMBER:							<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
SPOUSE OR SAME-SEX DOMESTIC PARTNER:							<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
							<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
							<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
							<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
							<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V
							<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V

## STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD 2013 ENROLLMENT FORM

**VISION PLAN SELECTION - ONLY AVAILABLE IF MEDICAL AND/OR DENTAL COVERAGE IS SELECTED**

### VISION PLAN - MONTHLY PREMIUMS AMOUNT

**DECLINE VISION COVERAGE**

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
Avesis	<input type="checkbox"/> \$4.83	<input type="checkbox"/> \$13.52	<input type="checkbox"/> \$16.86

### DENTAL PLANS - MONTHLY PREMIUMS AMOUNT

**DECLINE DENTAL COVERAGE**

Select A Plan	Retiree Only	Retiree + Adult	Retiree + Child	Retiree & Family
Delta Dental PPO Plus Premier	<input type="checkbox"/> \$35.94	<input type="checkbox"/> \$75.63	<input type="checkbox"/> \$60.48	<input type="checkbox"/> \$118.26
Total Dental Administrators	<input type="checkbox"/> \$8.99	<input type="checkbox"/> \$17.98	<input type="checkbox"/> \$17.51	<input type="checkbox"/> \$26.97

### MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT

**DECLINE MEDICAL COVERAGE**

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
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#### NON MEDICARE EPO PLANS

AETNA EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00
BCBSAZ/AMERIBEN EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00
CIGNA EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00
UNITEDHEALTHCARE EPO	<input type="checkbox"/> \$593.00	<input type="checkbox"/> \$1387.00	<input type="checkbox"/> \$1869.00

#### NON MEDICARE PPO PLANS

AETNA PPO	<input type="checkbox"/> \$943.00	<input type="checkbox"/> \$2219.00	<input type="checkbox"/> \$3074.00
BCBSAZ/AMERIBEN PPO	<input type="checkbox"/> \$943.00	<input type="checkbox"/> \$2219.00	<input type="checkbox"/> \$3074.00
UNITEDHEALTHCARE PPO	<input type="checkbox"/> \$943.00	<input type="checkbox"/> \$2219.00	<input type="checkbox"/> \$3074.00

#### NAU Only - Available in ALL regions NON MEDICARE

BCBS of Arizona PPO	<input type="checkbox"/> \$667.06	<input type="checkbox"/> \$1334.12	<input type="checkbox"/> \$1867.79
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**\*\*BENEFIT SERVICES DIVISION USE ONLY\*\***

PLAN NAME: \_\_\_\_\_

PLAN OPTION CODE: \_\_\_\_\_

**\*\*FOR MEMBERS WITH MEDICARE, MAKE MEDICAL ENROLLMENT SELECTIONS ON THE FOLLOWING PAGE\*\***

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD  
2013 ENROLLMENT FORM

**FOR MEMBERS WITH MEDICARE - You are required to attach a copy of your Medicare card**

I HAVE MEDICARE PART A

I HAVE MEDICARE PART B

**MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT - MEDICARE OPTIONS**

DECLINE MEDICAL COVERAGE

Select A Plan	Retiree Only with Medicare	Retiree + ONE: Both with Medicare	Retiree + ONE: One with Medicare, the other without	Retiree & Family With Medicare
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**EPO PLANS**

AETNA EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00
BCBSAZ/AMERIBEN EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00
CIGNA EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00
UNITEDHEALTHCARE EPO	<input type="checkbox"/> \$442.00	<input type="checkbox"/> \$878.00	<input type="checkbox"/> \$1024.00	<input type="checkbox"/> \$1166.00

**PPO PLANS**

AETNA PPO	<input type="checkbox"/> \$789.00	<input type="checkbox"/> \$1576.00	<input type="checkbox"/> \$1740.00	<input type="checkbox"/> \$1980.00
BCBSAZ/AMERIBEN PPO	<input type="checkbox"/> \$789.00	<input type="checkbox"/> \$1576.00	<input type="checkbox"/> \$1740.00	<input type="checkbox"/> \$1980.00
UNITEDHEALTHCARE PPO	<input type="checkbox"/> \$789.00	<input type="checkbox"/> \$1576.00	<input type="checkbox"/> \$1740.00	<input type="checkbox"/> \$1980.00

NAU Only - Available in ALL Regions

BCBS of Arizona PPO	<input type="checkbox"/> \$543.06	<input type="checkbox"/> \$1086.39	<input type="checkbox"/> \$1210.12	<input type="checkbox"/> \$1492.95
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***If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.***

I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true. I am aware that providing false information - including that which is related to my address, spouse, or dependent(s) - may subject me to denial of health benefits, disciplinary action, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACT).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return form to: ADOA, Human Resources Division, Benefit Services, 100 N. 15th Ave., Suite 103  
Phoenix, AZ 85007 or Fax 602-542-4744

**\*\*\* BENEFIT SERVICES DIVISION USE ONLY \*\*\***

PLAN NAME: \_\_\_\_\_

PLAN OPTION CODE: \_\_\_\_\_